

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/01/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155708		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 08/15/2016	
NAME OF PROVIDER OR SUPPLIER HILLSIDE MANOR NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1109 E NATIONAL HIGHWAY WASHINGTON, IN 47501			
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 9, 10, 11, 12, 15, 2016.</p> <p>Facility number: 000303 Provider number: 155708 AIM number: 100287530</p> <p>Census bed type: SNF: 3 SNF/NF: 39 Total: 42</p> <p>Census payor type: Medicare: 5 Medicaid: 32 Other: 5 Total: 42</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review by #02748 on August 22, 2016.</p>		F 0000	<p>Please accept the following POC as Hillside Manor's credible allegation of compliance We are cordially requesting a desk review for the validation of our compliance We believe that our auditing tools will support our changed systems and our monitoring programs shall support that deficiencies were corrected in a timely manner</p>			
F 0241 SS=E Bldg. 00	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents</p>						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview, and record review, the facility failed to ensure dental care was provided in a manner which promoted dignity for 2 of 2 residents who met the criteria for review of dignity during a dental examination (Resident #39, Resident #35) and 5 random observations of staff to resident interactions. (Resident #43, Resident #4, Resident #28, Resident #27, Resident #14)</p> <p>Findings included:</p> <p>1. During an interview and observation on 8/9/16 at 12:00 P.M., Resident #39 was sitting in a chair, in her room, and in no apparent distress. At that time Resident #39 indicated the last time she saw the Dentist here at the facility a staff member came to her room and took her to the back dining room/lounge and sat her down at a table. Resident #39 said, "It was very embarrassing" (indicating the dentist completed her dental exam and cleaning in the dining room/lounge in front of other residents). Resident #39 said, "I've never experienced a dental exam like that before."</p>			F 0241	<p>f241 Dignity & Respect Hillside Manor Nursing Home shall provide services to the residents that promotes and protects the resident's dignity In the specific sited incident of dental care, a remedy of assuring privacy during treatment or exams shall be re-enforced or a new dental contractor shall be provided to our residents A letter of agreement to use the resident's personal room or vacant room provided for examinations was sent to Primesource by this Administrator This poor practice of not affording all residents with due respect and dignity by services conducted in common areas does effect all residents requesting service and shall not occur at Hillside Manor This national company, while providing this service to our residents, shall be accompanied by a staff member or Social Service Director to assist and assure quality of service and dignity provided The services shall be in the privacy of the resident's room or vacant room designated by the facility staff Resident's privacy and dignity shall be afforded in general assessments, treatments, or services These services shall not occur in a common area Information in charting such items</p>		09/09/2016

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	<p>The clinical record for Resident #39 was reviewed on 8/12/16 at 1:45 P.M., diagnoses included, but were not limited to, asthma and hypertension.</p> <p>The Minimum Data Set (MDS) assessment for Resident #39 dated 7/3/16 indicated Resident #39 had a Brief Interview for Mental Status (BIMS) score of 15, indicating she was cognitively intact.</p> <p>A Nurse's Note dated 2/2/16 at 9:30 A.M., read as follows, "... [Name of company] dentistry here. Res [Resident] seen - 0 [no] N/O [new orders] @ [at] this time."</p> <p>A Nurse's Note, dated 3/8/16 at 1:30 P.M., read as follows, "... [Name of company] dentist here to see res. 0 new orders."</p> <p>2. During an observation and interview on 8/11/16 at 11:25 A.M., Resident #35 was observed sitting in a chair, in no distress. Resident #35 indicated, at that time, that when he last saw the dentist it was in the dining room/lounge located on the back hall. Resident #35 further indicated that other residents were sitting around and watched while the dentist completed his dental exam, indicating it was uncomfortable to be observed by</p>		<p>as food consumed, bowel movements, etc shall be obtained in a private conversation</p> <p>Residents will not be transported in any kind of geri chair or wheelchair in a backwards fashion</p> <p>All residents dignity could be compromised by not following guidelines to assure privacy and dignity An all staff inservice on September 8th, 2016 shall be held to re-enforce not to "drag" a resident backwards in any kind of geri chair or wheelchair, not to discuss residents private information in front of others, and to assure that outside vendors do not provide treatment or examinations in a common area for all others to view</p> <p>This proper execution of residents right to dignity and respect shall be reviewed each quarter by the QA Committee over the next 12 months and the DON or designee shall be responsible for the effective execution</p>				

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	<p>others.</p> <p>The clinical record for Resident #35 was reviewed on 8/11/16 at 2:39 P.M. Diagnoses included, but were not limited to, epilepsy and poor social situation.</p> <p>The Minimum Data Set (MDS) assessment, for Resident 35 dated 7/11/16, indicated Resident #35 had a Brief Interview for Mental Status (BIMS) score of 15, indicating he was cognitively intact.</p> <p>A Nurse's Note dated 3/8/16 at 1:00 P.M., read as follows, "...Res seen by [Name of company] dentist. - 0 N/O received."</p> <p>A schedule for dentist visit was provided by Social Services Director #1 on 8/11/16 at 11:15 A.M., and the form indicated Resident #39 and Resident #35 were last seen by the [Name of company] Dentist on 3/8/16. Resident # 39 received "Prophy" (cleaning of teeth) and Resident #35 received "Scaling".</p> <p>During an interview on 8/15/16 at 11:45 A.M., the Health Care Administrator was made aware Resident's had indicated the Dentist had performed dental exams in the dining room/lounge.</p>						

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	<p>3. During a random observation on 8/9/16 at 11:50 A.M., LPN #44 was observed to ask Resident #44 to come out of the dining room to have his blood sugar taken. Resident #43 got up and left the dining room with LPN #44. A few minutes later Resident #43 was observed to return to the dining room and take his seat at the rear of the dining room. At 11:56 LPN #44 was observed to come to the front of the dining room and yell loudly " Hey [name of Resident #43] come here" Resident #43 was seated in the back of the dining room at a table and got up abruptly.</p> <p>4. During the dining observation on 8/9/16 at 11:56 A.M., CNA #11 was observed to be pulling Resident #4 backwards in a broda chair (specialty wheel chair) into the dining room.</p> <p>5. During a random observation on 8/9/16 at 2:44 P.M., CNA #22 was observed to be standing inside the nursing station completing documentation. Resident #28 was observed to be ambulating down the hallway at that time. CNA #22 looked up and yelled "Hey [Name of Resident #28] did you have a bowel movement today?". At that time, the RN #10 and CNA #11 both in unison looked at CNA #22 and said "shhh". RN #10 was overheard to</p>						

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	<p>tell CNA #22 you can't yell that out like that. CNA #22 laughed and indicated she was sorry she just was used to asking like that.</p> <p>6. On 8/10/16 at 9:00 A.M., Resident # 27 was observed to be seated in a reclined position in his geri chair in the hallway near his room.</p> <p>At 9:10 A.M., Resident #27 was observed being pulled backward down the hallway towards the dining room in his geri chair by CNA #11. At that time Resident #27 was observed to be in a seated position with his feet down near the ground. Resident #27 was observed to be leaning forward and grabbing at the front of the geri chair.</p> <p>7. At 9:22 A.M. Resident #14 was observed in a geri chair being pulled backward down the hallway towards the dining room by CNA #15.</p> <p>During an interview on 8/10/16 at 9:30 A.M., CNA #22 indicated, the residents in geri chairs were pulled backwards because the chairs would sometimes go sideways if they pushed them forwards. CNA #22 indicated this was how they had been trained to push them and indicated it was just easier to do backwards.</p>						

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F 0242 SS=D Bldg. 00	<p>3.1-3(t)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on observation, interview, and record review, the facility failed to ensure resident's preferences were honored for 2 of 3 residents who met the criteria for review of smoking choices. (Resident #2, Resident #28)</p> <p>Findings include:</p> <p>A CNA Assignment sheet provided by the ADON (Assistant Director) on 8/9/16 at 10:00 A.M., indicated Resident #2 and Resident #28 were interviewable and smoked.</p> <p>During an observation on 8/9/16 at 12:30 P.M., Resident #2 and Resident #28 were observed safely smoking in the smoking area with a supervising staff member present.</p>		F 0242	<p>Hillside Manor shall endeavor to assure all residents are afforded the right to selective choices not in conflict with good sound nursing practices or facility policies Hillside Manor elects to remain a "Smoking Campus" in accordance with our facility policy The smoking policy has been re- evaluated over the years and has resulted in multiple guidelines and policies for the safety of all residents within Hillside Manor Among the many policies remain the premise that all smoking materials shall be secured by the facility and materials are to be issued and stored in the resident's appropriate nurses station Again this is for the safety of all residents Only those few that smoke are potentially effected by smoking policies The "Safe Smoking</p>		09/09/2016	

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	<p>1. The clinical record of Resident #2 was reviewed on 8/9/16 at 11:34 A.M. The record indicated Resident #2 was admitted to the facility on 2/1/04 with diagnoses including, but not limited to, schizophrenia.</p> <p>During an interview on 8/11/16 at 11:53 A.M., Resident #2 indicated the smoking policy was not fair and the rights of residents were not respected or encouraged because all residents had to smoke at the same time, with no regard to whether or not the resident required supervision. Resident #2 further indicated, smoke times were often up to an hour late and frequently did not get to smoke before she left the facility.</p> <p>The most recent Quarterly MDS (Minimum Data Set) assessment dated 7/4/16 indicated Resident #2 experienced no cognitive impairment.</p> <p>The August 2016 Physician's Order Recap included, but was not limited to, an order for "...to smoke withing [sic] facilities smoking policy..."</p> <p>A Safe Smoking Evaluation dated 7/7/16 indicated Resident #2 exhibited no potential risk factors related to smoking.</p>		<p>Evaluation" form shall remain in place but is limited in scope as it is directed toward safe handling of the smoking material. It does not address appropriate smoking times that could require modification due to extreme weather conditions, ie tornado warnings, heavy rains, extreme heat, extreme cold, winters storms and yet the resident insists on smoking NOW. Designated smoking times shall remain in the facility policy and all those that smoke shall be supervised by a designated facility staff member. The updated policy states that the entire facility is now a "supervised smoking facility". This change in practice was discussed in a resident council meeting held on August 31, 2016 and each smoker signed that they understood what "supervised" means to them and our facility. The residents were also informed that the new practice shall take place starting October 1, 2016. Until start time, all "safe" smokers shall have the right to obtain their personal smoking materials from the nurses station and head right out to the designated smoking area unattended during set times. The explanation of the revised smoking policy shall be made by the Administrator and all staff members shall be informed of the new practice on September 8, 2016 during an all staff in service. Again, the QA Committee shall</p>				

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	<p>A Care Plan dated 8/3/16 for, "Smoking" included the following interventions: "Ascertain resident's wishes about smoking, and respect resident's decision, Assess resident's ability to smoke safely, Instruct resident about the facility policy on smoking: locations, times, safety concerns, Notify charge nurse immediately if it is suspected resident has violated facility smoking policy, Instruct resident about smoking risks and hazards and about smoking cessation aids that are available, Observe clothing and skin for signs of cigarette burns, Consult with physician and dietician about resident's need for increased Vitamin C, Monitor oral hygiene."</p> <p>2. The clinical record of Resident #28 was reviewed on 8/11/16 at 2:30 P.M. The record indicated Resident #28 was admitted to the facility on 4/7/14 with diagnoses including, but not limited to, anxiety and depression.</p> <p>The most recent Quarterly MDS dated 7/4/16 indicated Resident #28 experienced no cognitive impairment.</p> <p>The August 2016 Physician's Order Recap lacked any documentation related</p>				<p>review the effectiveness and application of this new policy change for the next 4 quarters The SSD shall remain responsible for proper and timely staff assistance and cooperation in affording the residents right to smoke</p>		

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	<p>to smoking.</p> <p>A Safe Smoking Evaluation dated 7/7/16 indicated Resident #28 exhibited no potential risk factors related to smoking.</p> <p>A Care Plan dated 7/4/16 for, Smoking" included the following interventions: "Ascertain resident's wishes about smoking, and respect resident's decision, Assess resident's ability to smoke safely, Instruct resident about the facility policy on smoking: locations, times, safety concerns, Notify charge nurse immediately if it is suspected resident has violated facility smoking policy, Instruct resident about smoking risks and hazards and about smoking cessation aids that are available, Observe clothing and skin for signs of cigarette burns, Consult with physician and dietician about resident's need for increased Vitamin C, Monitor oral hygiene."</p> <p>During an interview on 8/11/16 at 3:00 P.M., the ADON (Assistant Director of Nursing) indicated all residents must be supervised during smoking times.</p> <p>The Policy and Procedure for "Smoking Policy" provided by the ADON on</p>						

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F 0248 SS=E Bldg. 00	<p>8/11/16 at 3:15 P.M. indicated, "...Residents who chose to smoke shall be evaluated using the "Safe Smoking Evaluation" form. The evaluation will determine whether or not the resident can safely smoke without supervision in the designated smoking area...If the resident is determined to be safe to smoke without supervision then the resident shall obtain his/her smoking materials from nursing station and proceed to designated smoking are [sic] unattended..."</p> <p>3.1-3(u)(1)</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on observation, interview, and record review, the facility failed to ensure activity programming was provided at the facility on weekends for 5 of 5 residents reviewed for activities. (Resident #59, Resident #39, Resident #15, Resident #21, Resident #43)</p> <p>Findings include:</p>	F 0248	<p>Hillside Manor shall provide an ongoing program of activities that will stimulate the mental, physical, spiritual, and psychosocial well-being of each resident To fall short of the above statement in anyway, while creating no physical harm, could negatively impact all residents A facility administrative change shall be implemented to remedy the loss of previous weekend activity volunteers The weekly</p>	09/09/2016			

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	<p>1. On 8/10/16 at 8:56 A.M., during interview with Resident #59, she indicated she was not sure if there were activities provided at the facility on weekends. Resident #59 also indicated she was not provided items to do activities on her own at the facility.</p> <p>On 8/10/16 at 2:27 P.M., Resident #59 was observed sitting on the couch in the TV area by the nurses station watching TV with other residents. No distress noted.</p> <p>On 8/11/16 at 8:15 A.M., Resident #59 was observed in bed, eyes closed.</p> <p>On 8/12/16 at 11:33 A.M., Resident #59 was sitting with other residents in lobby/TV area at nurses station, TV on in lobby.</p> <p>Resident #59's clinical record was reviewed on 8/10/16 at 2:20 P.M. Resident #59 had been admitted to the facility on 8/3/16. Diagnoses included, but were not limited to: schizophrenic disorder, depressive disorder, anxiety, medication non-compliance, and self-care deficit.</p> <p>On 8/10/16 at 2:51 P.M., during interview with the Assistant Director of Nursing (ADON), she indicated the</p>		<p>activity plan so scheduled by the full time AD shall incorporate and include an activity assistant, named volunteer, or the AD participating with and in scheduled activities 7 days per week</p> <p>Volunteers, assistants, and clergy shall be named within the monthly activity calendar In addition, a closet available 24 hours per day has been labeled "ACTIVITY CLOSET" to provide additional activity supplies for those residents seeking activities on their own This closet of activity supplies was discussed and requests made during the resident council meeting held August 31, 2016</p> <p>The AD shall be instructed to obtain the assistance of the activity volunteer group, schedule 7 day per week activities with named assistants, volunteers, or clergy for any times when she herself is not conducting the planned activity The AD will also be responsible for providing all materials for such assistants or volunteers The named assistants or volunteers may then chart participation and likes and dislikes</p> <p>The administrator shall be responsible for proper compliance to changes and directives of the AD and shall monitor effectiveness monthly for the next 6 months</p>				

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	<p>Admission Minimum Data Set (MDS) assessment had not been completed yet. An initial care plan completed on admission did not address activity interests.</p> <p>An activity evaluation dated 8/4/16, indicated an activity preference of somewhat important to do things with groups of people. Current activity interests included, but were not limited to, spiritual or religious activities, outside activities, trips, and shopping.</p> <p>Review of the current August activity calendar indicated since admission on 8/3/16, Resident #59 had attended an outing on 8/5/16, an ice cream social on 8/9/16, and bingo with exercise on 8/12/16. No weekend activities were documented or refused on the weekend of 8/6/16 and 8/7/16.</p> <p>On 8/11/16 at 9:21 A.M., the Activity Director was interviewed regarding the activity program at the facility. She indicated she was the only activity staff member at the facility. The Activity Director indicated she works Monday thru Friday usually 8:00 A.M. thru 4:00 P.M. or 4:30 P.M.. At that time, the facility activity calendar/programming for Saturday and Sundays were reviewed with the Activity Director. She indicated</p>						

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	<p>every Saturday exercises were scheduled at 10:00 A.M. and at 6:00 P.M. puzzles or games were scheduled. Each Sunday exercise was scheduled for 10:00 A.M., and devotions were scheduled for 6:00 P.M. The Activity Director indicated she did not know the name of the volunteer who was scheduled for devotions every Sunday at 6:00 P.M. The Activity Director explained no activity staff was scheduled for Saturdays or Sundays. She indicated the CNA's or a volunteer could get out games or puzzles for the residents.</p> <p>2. During an interview on 8/9/16 at 12:00 P.M., Resident #39 indicated there were not very many activities on the weekend and evenings. Resident #39 further indicated, they have a woman preacher that comes to the facility on Sunday's, but not much else.</p> <p>During an interview on 8/12/16 at 10:30 A.M., Resident #39 indicated there were not very many activities on the weekend and evenings. Resident #39 further indicated they have a woman preacher that comes to the facility on Sunday's, but not much else.</p> <p>3. On 8/10/16 at 2:27 P.M., Resident #15 was observed sitting in a chair by nurses station in the television area. Resident</p>						

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	<p>#15 had a stand up tray in front of her with a drink in reach.</p> <p>On 8/11/16 at 8:15 A.M., Resident #15 observed in bed, sleeping.</p> <p>On 8/10/16 at 3:15 P.M., Resident #15's clinical record was reviewed. Resident #15's diagnoses included, but were not limited to, dementia and hypertension. Her admission date was 6/10/16.</p> <p>Her admission Minimum Data Set (MDS) assessment dated 6/16/16, indicated a cognitive score of 8 (moderate cognitive impairment). Activity preferences included, but were not limited to, somewhat important to be around pets, keep up with the news, do things with groups of people, and go outside for fresh air.</p> <p>A 7/7/16 30 day scheduled MDS indicated a cognitive score of 15 (cognition intact).</p> <p>On 8/12/16 at 11:44 A.M., Resident #15's activity calendar for August 2016 was reviewed with the Activity Director. The Activity Director indicated Resident #15 had attended a singing group performance at the facility on August 2, 2016 (Tuesday). Resident #15 had refused all Monday thru Friday activities</p>						

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	<p>on 8/1/16, 8/3/16, 8/4/16, 8/5/16, 8/8/16, 8/9/16, and 8/10/16. The Activity Director indicated Resident #15 had been hospitalized on 8/11/16. Review of Resident #15's June and July 2016 activity calendar, at that time, indicated documentation was lacking of any activities provided or refused on every Saturday or Sunday.</p> <p>4. Resident #21's activity care plan with an initial care plan date of 6/13/16, indicated activity preferences of watching television and going outside. The care plan goal was "Resident will attend group activity of interests at least once weekly through next review date."</p> <p>During interview with the Activity Director on 8/12/16 at 11:49 A.M., she indicated the last weekend she worked at the facility was on Father's Day in June 2016. The Activity Director indicated she did not have a specific activity plan for weekend activities. She indicated there was a closet (where games were kept) for CNA's to "keep residents occupied with games." She indicated there were no extra CNA's scheduled on weekends to provide activity programming for the residents. The Activity Director indicated she did not know which volunteers came in for the weekends. The Activity Director also indicated she leaves the</p>						

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	<p>facility between 4:00 P.M. and 4:30 P.M. on week days. She indicated every Wednesday evening a church group was scheduled for 6:00 P.M., at the facility. Every other week day evening, puzzles and games were on the calendar for 6:00 P.M. She indicated it was left up to the CNA's to get out puzzles and games on weekday evenings for the residents. At that time, the June 2016 and July 2016 activity calendar for all residents at the facility was reviewed with the Activity Director. Documentation was lacking of any activities provided or refused for all Saturday and Sundays of these 2 months and the first week of August 2016 for all residents residing at the facility. The Activity Director was made aware, at that time, a planned activity program to meet the needs of the residents was lacking at the facility on the weekends. The Activity Director indicated she understood.</p> <p>5. Resident #43's activity attendance records were reviewed for the month of June, July, and August 2016. The attendance records lacked any documentation Resident #43 attended any activities on the weekend during those 3 months.</p> <p>On 8/12/16 at 12:15 P.M., during interview with the Activity Director, she agreed documentation was lacking for all</p>						

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F 0282 SS=D Bldg. 00	<p>residents at the facility of activities being provided on weekends in June, July, and the 1st week of August 2016.</p> <p>3.1-33(c)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to ensure medications were administered as ordered by the physician for 1 of 1 resident reviewed for medication errors. (Resident #21)</p> <p>Findings include:</p> <p>On 8/12/16 at 8:40 A.M., Resident #21's clinical record was reviewed. Resident #21 had been admitted to the facility on 7/22/15. His current diagnoses included, but were not limited to, dementia, coronary artery disease, and chronic kidney disease stage 3.</p> <p>His current routine August 2016 Physician Orders included, but were not limited to, "... ASPIRIN *EC [enteric coated]* 325 MG [milligrams]</p>		F 0282	<p>All medications administered to residents at Hillside Manor shall be done so accurately and correctly as ordered by the physician While the cited issue of error involved a wrong dosage of aspirin and affected only one resident, the lack of proper procedure in managing the medication change could have serious impact on several residents All nursing personnel and QMAs shall be re-educated in a comprehensive in service held on September 8th, 2016 that will include "the proper procedure in receiving med orders and dispensing medication" The review shall include completing the MAR sheets properly to show 1) Right Patient, 2) Right Medication, 3) Right dosage, 4) Right route of delivery, and 5) Right Time The DON/ADON shall be responsible for the "re-education"</p>		09/09/2016	

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	<p>ECOTRIN 325 MG [milligrams] TAKE (1) TABLET BY MOUTH ONCE DAILY..." Order date for Aspirin was 2/11/16.</p> <p>On 8/12/16 at 9:05 A.M. Resident #21 was observed sitting in his recliner in his room.</p> <p>On 8/12/16 at 8:40 A.M., Resident #21's medications were reviewed with the Assistant Director of Nursing (ADON) during the morning medication pass. One bottle of Aspirin 81 mg was observed. The label instructed 81 mg (enteric coated) with instructions to take one tablet by mouth once a day for heart or circulation.</p> <p>The August 2016 the Medication Administration Record (MAR) had documentation that Aspirin 325 mg had been administered daily in August 2016 from the 1st to the 11th at 8:00 A.M.</p> <p>On 8/12/16 at 8:40 A.M., the ADON indicated, the 81 mg of Aspirin had been administered instead of the Aspirin 325 mg that had been ordered.</p> <p>During an interview on 8/15/16 at 9:02 A.M., the ADON indicated, Resident #21 had used all the Aspirin he had received from the facility pharmacy before starting</p>				<p>and in service of all nursing personnel The DON/ADON shall perform a random audit of a nurse 3 times per week, to include at least 5 residents during a med pass, for the next 6 months to assure that the proper compliance of receiving, recording, administering, and discontinuing medications is taking place daily</p>		

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F 0329 SS=D Bldg. 00	<p>the current bottle of Aspirin in use from the Veteran's Administration. The ADON indicated there had been 120 pills in the current new bottle when dispensed and 98 tabs were left at present. The ADON indicated 22 tablets of Aspirin 81 mg had been administered to Resident #21. She further indicated Resident #21 had received the wrong dose for a total of 22 days.</p> <p>3.1-35(g)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue</p>						

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	<p>these drugs.</p> <p>Based on observation, interview, and record review, the facility failed to ensure an anti-anxiety medication was clinically indicated for 1 of 5 residents who met the criteria for review of unnecessary medications. (Resident #29)</p> <p>Findings include:</p> <p>The clinical record of Resident #29 was reviewed on 8/15/16 at 8:59 A.M. The record indicated the diagnoses of Resident #29 included, but were not limited to, psychosis, depression, and anxiety.</p> <p>A Significant Change MDS (Minimum Data Set) assessment dated 1/21/16 indicated Resident #29 experienced moderate cognitive impairment, inattention and disorganized thinking, no mood impairment, and no behaviors,</p> <p>The most recent Quarterly MDS dated 7/12/16 indicated Resident #29 experienced minimal cognitive impairment, no inattention or disorganized thinking, minimal mood impairment, and no behaviors.</p> <p>A Behavioral Health Progress note dated 5/10/16 indicated Resident #29 experienced no agitation.</p>	F 0329	<p>Hillside Manor shall not administer antipsychotic drugs unless the drug therapy is necessary to treat a specific condition that is diagnosed and documented and after non drug interventions have been attempted</p> <p>Hillside Manor shall properly document in nursing notes or social service notes behavioral incidents justifying or validating the prescribed antipsychotic drug therapy Hillside Manor may accept a physicians order for anti anxiety medication, after a clinical diagnosis and documented incidents are not resolved with non drug intervention An ongoing effort of drug reduction should be in place</p> <p>All residents could be effected by receiving unnecessary drug therapy Only one resident was effected by this practice</p> <p>Hillside Manor shall, through a comprehensive in service on September 8th, 2016 educated all nursing personnel and SSD that anti psychotic drug therapy shall only occur with supportive documented incidents It should also contain non drug interventions attempted and should include an effort for drug reduction</p> <p>The DON/ADON shall be responsible for proper "re-education" and in service of all nursing personnel The DON/ADON shall review all new</p>		09/09/2016		

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	<p>The nursing notes from 5/15/16 at 9:15 P.M. through 5/27/16 at 12:15 P.M. were reviewed and lacked any documentation to indicate Resident #29 experienced agitation.</p> <p>The May 2016 Psychoactive Medication Monthly Flow Record from 5/1/16 through 5/27/16 indicated Resident #29 experienced no target behaviors of paranoia or hallucinating and lacked any documentation to indicate Resident #29 experienced agitation.</p> <p>A Physician's Progress note dated 5/27/16 at 11:12 A.M. indicated, "...Current problems include anxiety (also increased confusion, agitation [sic] and acting out. Generally this happens around 4pm [sic]...alert (sitting at the table, eating lunch. Talking and interactive.)...Cooperative...not in acute distress...oriented...will start slow dose of ativan [sic]..."</p> <p>An untimed Physician's Telephone Order dated 5/27/16 a new order of, "Ativan [an anti-anxiety medication] 0.5 mg [milligrams] q [every] 1200 [12:00 P.M.] for agitation"</p> <p>A Nursing note dated 5/27/16 at 12:30 P.M. indicated, "[name of Family Nurse</p>				<p>or changed orders for antipsychotic medications for the next 3 months to assure there is proper documentation that warrants an increase or change The DON/ADON/SSD and pharmacy consultant shall continue to meet monthly to evaluate all residents for proper and necessary Gradual Dose Reductions This GDR meeting and recommendations made during the meetings shall be reported monthly to the QA Committee over the next 6 months</p>		

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F 0332 SS=D Bldg. 00	<p>Practitioner] here for rounds. N.O. [new order] rec'd [received] et [and] noted for ativan [sic] 0.5 mg [1] po [by mouth] @ [at] 1200 [12:00 P.M.] for agitation..."</p> <p>The Social Service History and progress notes from 10/15/15 through 8/16/16 lacked any documentation to indicate Resident #29 experienced agitation.</p> <p>During an interview on 8/15/16 at 11:00 A.M., the ADON (assistant Director of Nursing) indicated Resident #29 experienced agitation and confusion related to an infection during the first two weeks of May 2016, but concluded after the infection resolved. The ADON further indicated, no documentation could be provided to indicate a clinical indication for the use of Ativan 0.5 mg daily. The ADON then indicated it is the usual policy of the facility to ensure medications are clinically indicated.</p> <p>3.1-48(a)(4) 3.1-48(a)(2)</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.</p>						

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	<p>Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5%, in that, the facility had 3 medication errors out of 30 opportunities for error, resulting in a 10.0% error rate. This affected 2 of 11 residents observed during the medication pass (Resident #21, Resident #39) and 1 of 4 nurses observed to pass medications (LPN #5)</p> <p>Findings include:</p> <p>On 8/12/16 at 9:05 A.M., Resident #21 was observed sitting in his recliner in his room, no distress noted.</p> <p>1. On 8/12/16 at 8:19 A.M., LPN #5 began to prepare Resident #21's 8:00 A.M. medications. LPN #5 placed 1 and 1/2 tablets of potassium chloride 20 MEQ (milliequivalents) in a clear medication cup. The label of the potassium chloride 20 MEQ bottle indicated to administer one-half tablet orally once a day for potassium supplementation. LPN #5 indicated she was going to administer 1 and 1/2 tabs. LPN #5, then indicated, the label indicated one and 1/2 tablets in A.M. LPN #5 was made aware at that time, that the label instructed to administer 1/2 tablet of potassium chloride 20 meq in A.M. LPN # 5 read the label again and</p>		F 0332	<p>Hillside Manor shall strive for excellence and have zero medication errors Any form of medication delivery that is not exactly the correct resident, correct medication, the right dosage, the right route, and the right time shall not be tolerated at Hillside Manor Any medication delivery that is not exact could have negative or sometimes Along with a September 8th, 2016 scheduled in service for all nursing personnel on medication delivery, two changes will be made in procedures of medication delivery that will assist the licensed nurses or QMA to achieve accuracy 1)The 90 day supplied bottles of meds from the Veterans Administration were/are difficult/unlawful to re-label to match the new orders from the attending physicians when delivery time or amount changed The pharmacy consultant has agreed to provide "Direction Change Labels" that may be added to the existing label to indicate the changed order and match the MAR sheet and notes that a new complete and correct label has been requested from VA 2) The monthly re-writes of the MAR shall now include the instruction "wait 10 minutes before applying additional optic ointment or drops" and also "rinse mouth with water and spit the water out after the inhaler use" to prevent dry mouth These initialed instructions should serve as a</p>		09/09/2016	

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	<p>agreed the label indicated to administer 1/2 tablet of potassium chloride 20 meq in am.</p> <p>On 8/12/16 at 8:26 A.M., LPN # 5 indicated she would check the physician's order in the clinical record regarding the potassium chloride order.</p> <p>On 8/12/16 at 8:40 A.M., LPN #5 and the Assistant Director of Nursing (ADON) reviewed Resident #21's potassium medication bottle (label) with the physician's orders and the Medication Administration record (MAR). The routine August 2016 Physician's Orders for Resident #21 included, but was not limited to, a potassium chloride medication, 10 meq tablet to be given daily at 8:00 A.M. (ordered 7/22/16) and had been discontinued. A telephone order dated 7/29/16, indicated, "... N.O. [new order] Potassium CL [chloride] er [extended release] meq [milliequivalent] 1 20 mg tablet [sic] [1- 20 meq tablet] dly [daily]..."</p> <p>On 8/12/16 at 9:42 A.M., the ADON [Assistant Director of Nursing] was interviewed regarding the current (7/29/16) potassium chloride medication order. The ADON indicated Res #21 should be receiving one tablet of 20 meq daily not a one-half tablet of 20 meq of</p>		<p>reminder to the staff All nursing personnel shall be in serviced on the "Direction Change Label" on September 8th, 2016 The DON/ADON shall perform a random audit of a nurse 3 times per week, to include at least 5 residents during a med pass, for the next 6 months to assure that the proper compliance of receiving, recording, administering, and discontinuing medications is taking place daily The DON/ADON, responsible for re writes shall assume responsibility for the chart review and the accuracy of the physicians orders</p>				

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	<p>potassium or a one and one-half tablet of potassium.</p> <p>On 8/12/16 at 9:54 A.M., LPN #5 indicated, the one and 1/2 tablets of potassium chloride 20 meq she had prepared was not the correct dose to administer.</p> <p>2. On 8/12/16 at 9:05 A.M., LPN #5 entered Resident # 21's room to administer his A.M. oral medications and eye drops. LPN #5 washed her hands before entering Resident #21's room with his medications. LPN # 5, after administering the oral medications, applied her gloves and administered one drop of Latanoprost 0.005% (an anti-glaucoma medication) eye medication into each eye. LPN #5 then removed her gloves and applied another pair of gloves. LPN #5 then inverted the bottle of Timolol (an anti-glaucoma medication) 0.5% eye drops and applied a drop of Timolol in each of the resident's eyes. The eye drops were applied within 2 minutes between the Latanoprost drops and the Timolol eye drops.</p> <p>The facility's drug book entitled, "PDR [Physician's Desk Reference] 2016 EDITION NURSES'S DRUG HANDBOOK" was reviewed on 8/12/16</p>						

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	<p>at 11:25 A.M. On page 1061 of the PDR under under the drug of Timoptic-timolol maleate, under the heading of concomitant medication the following was included, "Administer other topically applied ophthalmic medications at least 10 min [minutes] before Timoptic ..."</p> <p>On 8/12/16 at 11:28 A.M., the ADON provided the facility policy, entitled, "SPECIFIC MEDICATION ADMINISTRATION PROCEDURES [undated]." The policy included, but was not limited to, "...K. Wait at least five (5) minutes before applying additional medication to the eye..." The ADON indicated, at that time, she had talked to LPN #5 and LPN # 5 and had indicated she had not timed between the 2 different eye medications administered.</p> <p>3. During a medication observation on 8/12/16 at 9:48 A.M., Resident #39 was administered an inhaler by LPN #12. After the administration of 2 puffs of the Spiriva 18 mcg inhaler [a medication that helps relieve asthma patients breathing problems], the resident was not instructed to rinse her mouth and spit the water out.</p> <p>The clinical record for Resident #39 was reviewed on 8/12/16 at 1:45 P.M., the diagnoses included, but were not limited to, asthma, and hypertension.</p>						

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	<p>The Minimum Data Set (MDS) assessment for Resident 39 dated 7/3/16 indicated Resident #39 had a Brief Interview for Mental Status (BIMS) score of 15, indicating she was cognitively intact.</p> <p>A Medication Administration Record dated 8/1/16 thru 8/31/16 read as follows. "...SPIRIVA 18 MCG C-P HANDIHALER 1 CAPSULE IN HANDIHALER ONCE DAILY..."</p> <p>During an interview on 8/12/16 at 11:23 A.M., LPN #10 indicated that when she administered a Spiriva inhaler to a resident she had the resident take a drink of water, rinse and spit the water out. LPN #12 indicated this procedure prevented the resident's mouth from becoming sore.</p> <p>During an interview on 8/12/16 at 1:45 P.M., the Assistant Director of Nursing (ADON) indicated that the proper technique for administering a Spiriva Inhaler was to have the resident rinse the mouth after the administration of the medication.</p> <p>The policy and procedure policy for 'SPECIFIC MEDICATION ADMINISTRATION PROCEDURES' provided by the ADON on 8/12/16 at</p>						

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F 0364 SS=E Bldg. 00	<p>1:45 P.M., read as follows, "...L. Have resident rinse his/her mouth and spit out the rinse water..."</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, interview, and record review, the facility failed to ensure recipes were followed in the preparation of pureed foods for 1 of 2 observations of puree meal preparation. This had the potential to affect four residents who received pureed foods.</p> <p>Findings include:</p> <p>During an observation on 8/12/16 at 10:22 A.M., Cook #2 indicated she was making four servings of puree fish fillets. At that time she was observed to place four fish fillets into the food processor and turn on the lid. She then took a full coffee crafe of hot water and added an unmeasured, undetermined amount to the</p>		F 0364	<p>Hillside Manor shall strive to deliver food that meets the nutritional standards of calories while delivering foods that are palatable, attractive, and maintain proper temperature Providing pureed foods to meet clinical requirements of resident safety must be afforded extra effort to maintain flavor (taste) and proper temperature The caloric intake and health of those residents relying on pureed foods for nourishment hinges upon the food being palatable All such residents could be negatively impacted if the pureed foods are not prepared properly An all dietary in service set for September 2, 2016 and September 7th, 2016 shall be conducted by the RD on how to properly puree different kinds of</p>		09/09/2016	

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	<p>food processor and continued to process the mixture.</p> <p>The recipe dated 7/16/15 titled "Pureed Fish Fillets" was reviewed with Cook #2 on 8/12/16 at 10:30 A.M. It included but was no limited to, "... Measure desired # [number] of servings into food processor. Blend until smooth. Add broth or gravy if product needs thinning..." At that time during an interview Cook #2 indicated she normally would use gravy or broth but today they didn't have any need to prep gravy so they did not make any. A small amount of the puree fish was sampled, it was bland and tasted watered down. Cook #2 agreed the meat was bland and would need to be redone.</p> <p>During an interview with dietary manager on 8/15/16 at 9:40 A.M., she indicated she had in-serviced the dietary staff on following recipes in regards to puree food preparation. She indicated plain water should not be used to thin out puree food unless the recipe calls for it.</p> <p>An undated policy titled "Texture Altered Diets" was provided on 8/15/16 at 12:20 P.M. It included, but was not limited to, "...Place the number of portions needed into blender with appropriate liquid...at quantity needed per recipe per serving..."</p>		<p>foods to make them palatable, conserve their nutritive value, and maintain proper temperature until served</p> <p>The in service shall include, as usual, pre and post test questions and at the digression of the RD, return demonstration</p> <p>The DM and RD shall monitor the procedures in use for preparing pureed foods for the next 6 months The DM or designee shall perform pureed food audits 3 times per week for the next 3 months</p> <p>The RD shall incorporate compliance and monitoring within her exit notes to the administrator The DM and Administrator shall be responsible for proper compliance of standards and procedures in place Audit tools shall be reported to the QA Committee over the next 6 months</p>				

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F 0371 SS=F Bldg. 00	<p>3.1-21(a)(1) 3.1-21(a)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure dishwasher temps were adequate in a low temperature dishwasher for 2 of 2 cycles watched and 15 of 15 days reviewed on the facility dishwasher logs. This deficient practice had the potential to affect 37 of 37 residents residing in the facility.</p> <p>Findings include:</p> <p>During an observation of Dining Room Assistant #4 washing the breakfast dishes on 8/15/16 at 8:45 A.M. The temperature gage was observed to be reading 108 degrees Fahrenheit during the wash cycle. The dietary manager ran the dishwasher again and the temperature was observed to reach 110 degrees Fahrenheit. The dietary manager indicated the machine was low temperature and sanitized with a chemical solution. At that time she</p>		F 0371	<p>Hillside Manor has a low temperature dishwasher machine The machine shall be adjusted to maximize the effectiveness of the contracted chemicals purchased to sanitize and wash dishes effectively No residents were in jeopardy due to the water temperature of the dishwasher being at 108 F or 110F The chemical manufacturer sent guidelines to the survey team and this Administrator stating in writing that the low temperature machines with 50 to 100 PPM (sanitizer) should have water temperatures of at least 38 degrees C (99F) Hillside Manor will remedy any question about water temperature and turn up the water heater for the dishwasher to reach the temperature of at least 120 F All dietary staff shall be in serviced on dishwasher water temperature settings on September 2, 2016 The DM or designee shall examine the water temperature at least 3 times per week for the</p>		09/09/2016	

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	<p>checked the solution in the machine with a test strip and it was observed to be reading at 100 ppm (parts per million). A chart on the wall above the dishwasher was observed and indicated the temperature during the wash cycle of the machine should be at least 120 degrees.</p> <p>The "Dishwasher Temperature Log" for August 2016 was reviewed. At the top of the log was a handwritten note "120 - 140 [symbol for degrees]" Fahrenheit. The temperatures for the dishwasher was documented at each meal daily. All of the wash temperatures were documented as being 5 to 20 degrees below the 120 degree Fahrenheit range.</p> <p>During an observation on 8/15/16 at 11:33 A.M., Cook #2 was observed to be using the 3 compartment sink to wash dishes. She indicated at that time that they were not using the dishwasher until the temperature concerns were resolved.</p> <p>During an interview with the HFA (Health Facility Administrator) on 8/15/16 at 12:15 P.M., she indicated they were going to turn up the hot water heater for the dishwasher to correct the concern.</p> <p>An policy dated 9/14 was provided and included, but was not limited to "If</p>				<p>next 3 months to assure the temperature is at or above the 120 F</p> <p>The DM shall remain responsible for the purchase of the sanitizer, proper instruction for its use, and proper monitoring of accurate and acceptable water temperatures</p> <p>This responsibility will be perpetual</p>		

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F 0425 SS=D Bldg. 00	<p>temperature is below manufacture's recommendations, stop using the dishwasher until temperatures reach the required range. If temperatures do not reach the required range, contact your Maintenance Department or dishwasher manufacturer...Note action taken in far right -hand column..."</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, interview, and record review, the facility failed to ensure pharmacy services not provided by the</p>		F 0425	Hillside Manor shall strive for excellence and have zero medication erros Any form of medication delivery that is not		09/09/2016	

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	<p>facility ensured correct dosage and labeling of medications for 1 of 1 resident reviewed that did not utilize the facility's pharmacy. (Resident #21)</p> <p>Findings include:</p> <p>1. On 8/12/16 at 8:19 A.M., LPN #5 began to prepare Resident #21's 8:00 A. M. medications. LPN #5 placed 1 and 1/2 tablets of potassium chloride 20 MEQ (milliequivalents) in a clear medication cup. The label of the potassium chloride 20 MEQ bottle indicated to administer one-half tablet orally once a day for potassium supplementation. LPN #5 was asked if the 1 and 1/2 tablets was the dosage she was going to administer. She indicated yes. LPN #5, then indicated the label indicated one and 1/2 tablets in am. LPN #5 was made aware, at that time, that the label instructed to administer 1/2 tablet of potassium chloride 20 meq in am. LPN # 5 read the label again and agreed the label indicated to administer 1/2 tablet of potassium chloride 20 meq in am.</p> <p>On 8/12/16 at 8:26 A.M., LPN # 5 indicated she would check the physician's order in the clinical record regarding the potassium chloride order.</p> <p>On 8/12/16 at 8:40 A.M., LPN #5 and the</p>		<p>exactly the correct resident, correct medication, the right dosage, the right route, and the right time shall not be tolerated at Hillside Manor Any medication delivery that is not exact could have negative or sometimes Along with a September 8th, 2016 scheduled in service for all nursing personnel on medication delivery, two changes will be made in procedures of medication delivery that will assist the licensed nurses or QMA to achieve accuracy 1)The 90 day supplied bottles of meds from the Veterans Administration were/are difficult/unlawful to re-label to match the new orders from the attending physicians when delivery time or amount changed The pharmacy consultant has agreed to provide "Direction Change Labels" that may be added to the existing label to indicate the changed order and match the MAR sheet and notes that a new complete and correct label has been requested from VA 2) The monthly re-writes of the MAR shall now include the instruction "wait 10 minutes before applying additional optic ointment or drops" and also "rinse mouth with water and spit the water out after the inhaler use" to prevent dry mouth These initialed instructions should serve as a reminder to the staff All nursing personnel shall be in serviced on the "Direction Change Label" on September 8th, 2016 The</p>				

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	<p>Assistant Director of Nursing (ADON) reviewed Resident # 21's medication bottle (label) with the physician's orders and the Medication Administration Record (MAR). The routine August 2016 physician's orders for Resident #21 included, but was not limited to, a potassium chloride medication, 10 meq tablet to be given daily at 8:00 A.M. (ordered 7/22/16) and had been discontinued. A telephone order dated 7/29/16, indicated, "... N.O. [new order] Potassium CL [chloride] er [extended release] meq [milliequivalent] 1 20 mg tablet [sic] [1- 20 meq tablet] dly [daily]..."</p> <p>On 8/12/16 at 9:42 A.M., the ADON was interviewed regarding the current (7/29/16) potassium chloride medication order. The ADON indicated Resident #21 should be receiving one tablet of 20 meq daily not a one-half tablet of 20 meq of potassium or a one and one-half tablet of potassium.</p> <p>On 8/12/16 at 9:42 A.M., the ADON was interviewed regarding the current (7/29/16) potassium chloride medication order. The ADON indicated Resident #21 now received his medications from the Veteran's Administration. The ADON indicated the label was incorrect in regard to the current 7/29/16 physician's order.</p>				<p>DON/ADON shall perform a random audit of a nurse 3 times per week, to include at least 5 residents during a med pass, for the next 6 months to assure that the proper compliance of receiving, recording, administering, and discontinuing medications is taking place daily The DON/ADON, responsible for re writes shall assume responsibility for the chart review and the accuracy of the physicians orders</p>		

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	<p>The ADON indicated, at that time, medications received from the Veteran's Administration were not checked when received by the facility. The ADON indicated the medications should be checked by the nurses when administering each medication. The ADON also indicated, at that time, she was unsure if the label of a medication provided by the Veteran's Administration could be changed if the medication dosage/order was changed.</p> <p>2. On 8/12/16 at 8:40 A.M., Resident #21's clinical record was reviewed. Resident #21 had been admitted to the facility on 7/22/15. His current diagnoses included, but were not limited to, dementia, coronary artery disease, and chronic kidney disease stage 3.</p> <p>His current routine August 2016 Physician Orders included, but were not limited to, "... ASPIRIN *EC [enteric coated]* 325 MG [milligrams] ECOTRIN 325 MG [milligrams] TAKE (1) TABLET BY MOUTH ONCE DAILY..." Order date for Aspirin was 2/11/16.</p> <p>On 8/12/16 at 9:05 A.M. Resident #21 was observed sitting in his recliner in his room.</p>						

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	<p>On 8/12/16 at 8:40 A.M., Resident #21's medications were reviewed with the Assistant Director of Nursing (ADON) during the morning medication pass. One bottle of Aspirin 81 mg was observed. The label instructed 81 mg (enteric coated) with instructions to take one tablet by mouth once a day for heart or circulation.</p> <p>The August 2016 the Medication Administration Record (MAR) had documentation that aspirin 325 mg had been administered daily in August 2016 from the 1st to the 11th at 8:00 A.M.</p> <p>On 8/12/16 at 8:40 A.M., the ADON indicated the 81 mg of Aspirin had been administered instead of the Aspirin 325 mg that had been ordered.</p> <p>During an interview on 8/15/16 at 9:02 A.M., the ADON indicated Resident #21 had used all the Aspirin medication he had received from the facility pharmacy before starting the current bottle of Aspirin in use from the Veteran's Administration. The ADON indicated there had been 120 pills in the current new bottle when dispensed and 98 tabs were left at present. The ADON indicated Resident #21 had used 22 tabs of the 81 mg Aspirin receiving the wrong dose for 22 days.</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	<p>On 8/15/16 at 9:20 A.M., the ADON indicated the facility had no policy regarding the use of medications from the Veteran's Administration.</p> <p>On 8/15/16 at 11:16 A.M., during an interview with the ADON, she indicated in regard to the use of medications from the Veteran's Administration, she now had some blank labels to use for changes in medication dosages.</p> <p>3.1-25(g)(1)</p>						